Committee Meeting

of

ASSEMBLY REGULATORY OVERSIGHT COMMITTEE

"Examine the record of the Office on Minority and Multicultural Health's implementation of the Eliminating Health Disparities Initiative; update from the Division of Investments on its progress in divesting the pension portfolio from foreign companies with ties to the Sudan, with an update on the current status of the conflict in Darfur"

LOCATION: Committee Room 14
State House Annex
Trenton, New Jersey

DATE: March 9, 2006
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman William D. Payne, Chair
Assemblyman Alfred E. Steele, Vice Chair
Assemblyman Peter J. Barnes Jr.
Assemblyman Samuel D. Thompson

ALSO PRESENT:

James F. Vari
Office of Legislative Services
Committee Aide

Nicole Brown
Assembly Majority
Committee Aide

Kristin Antonello
Assembly Republican
Committee Aide

Meeting Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

ASSEMBLYMAN WILLIAM D. PAYNE (Chair): Good morning. My goodness, I apologize for starting this hearing late. We had some matters that we had to clarify.

We're going to hear on the disparities -- we're going to deal with disparities this morning.

First, let me call this meeting to order, first of all. The meeting of the Regulatory Oversight Committee will come to order, and I'd like to call the roll.

MR. VARI (Committee Aide): Assemblyman Thompson?

ASSEMBLYMAN THOMPSON: Here.

MR. VARI: Assemblyman Barnes?

ASSEMBLYMAN BARNES: Here.

MR. VARI: Vice Chairman Steele?

ASSEMBLYMAN STEELE: Here.

MR. VARI: Chairman Payne?

ASSEMBLYMAN PAYNE: Here.

Thank you very much.

As you know, the Committee -- we will examine the record of the Office of Minority and Multicultural Health's implementation of the Eliminating Health Disparities initiative. The law, as you know, requires the office to develop and implement a comprehensive, coordinated plan to reduce health disparities between white, and racial and ethnic minority populations in this state in a number of areas. And we're going to hear first.

And secondly, we will hear the status report on the Sudan divestiture legislation that we passed and signed into law last year. But we're going to hear on the health disparities area first.

Our concern, of course-- I'd just like to say that we have known for a long time that there is a great disparity in the accessibility to health care for people in the communities -- that there is a tremendous difference between the quality of care that minorities receive in our communities. We know that that results in a very high incidence of infant mortality. We know that people in these poor and minority communities are the ones who suffer from all kinds of illnesses that exist within those communities and not elsewhere -- things like asthma, and things of that nature.

We will be talking on Monday about lead poisoning and the advent of that. And that's a very serious problem. And the concerns that we have is that we talk often about these things -- we are aware of them; that we sometimes introduce or develop certain kinds of plans to address these problems -- and then we come back in a year, or two, or three, and the problems persist, or they're still there.

What we want to find out today is whether or not there are, in fact, some initiatives that will address these problems -- some initiatives that have been implemented. We need to see examples of where we're working, because it is extremely frustrating for all of us. When we step out of the role of elected officials or out of the State House and walk through the communities or visit with the people who are suffering unnecessarily from an illness that impact on them, then it's extremely disturbing. I see sometimes we, perhaps, are in some kind of -- not Ivory Tower necessarily -- but it becomes academic. That we just study and we hear about these things and do nothing about them, and that it seems like just a symbol -- symbolic kinds of activities.

In the meantime, we have people who continue to suffer from the kinds of illness that they don't need to. That we do know ways to improve these -- we know them. But we have to have the will, I suppose, to follow through on it. And I think it is important for us, as legislators, not only to pass legislation, but to also follow up on it, to make sure it's being implemented and carried out. If, in fact, we hear from the community that works in this area-- What are their needs? Always money -- it seems like money is one of the things that's at the bottom of it. But there are other kinds of practices that we can, in fact, carry out without additional moneys. And I think we need to look for ways there, too.

But we simply cannot continue to have the people on the lowest rung of the ladder being the ones who suffer over and over again, simply because the general community will not provide the transportation, for instance, for people to go get dialysis. Those are the kinds of things that happen that cut out -- close some centers, and people have to go to another center, for instance, for treatment. Yet, there's no bus to take them to that treatment. So those are the kinds of things we have to look at and correct those things, I think.

But we want to hear from you. I'd like to see whether or not either of my colleagues would like to have a statement, or anything, at the beginning of this? (no response)

If not, we will continue. I would like to welcome Ms. Linda Holmes, from the New Jersey Department of Health and Senior Services, who would like to make a statement.

L I N D A H O L M E S: Thank you very much, Chairman Payne and members of the Committee, for this opportunity to address the full Committee.

ASSEMBLYMAN PAYNE: Press -- is the mike on, please? (referring to PA microphone) The red light should show up. It's on.

MS. HOLMES: Okay. I am Linda Holmes. And I am the Director of the Office of Minority and Multicultural Health, within the Department of Health and Senior Services. Again, thank you for this opportunity. I will be talking about some of the health disparities initiatives that currently exist in the Department, as well as talking about where we go from here.

Addressing health disparities is the core mission of the Department of Health and Senior Services. And while recognizing that there are difficulties and complexities inherent in this challenge, our Commissioner of Health, Dr. Fred Jacobs, continues to make working to reduce health disparities the Department's number one priority.

As you know, Assemblyman Payne, legislation created the Office of Minority and Multicultural Health some years ago. And then, in 2001, the Office was renamed, and that was the first time that the Office received funding. The law charged the Office with identifying and developing innovative projects to improve health outcomes among minorities. The ultimate goal of this legislation was to enable all members of racial and ethnic groups to access high quality health care, as you mentioned.

From its inception, the Office included raising awareness about the deeply rooted problems of disparities. For example, the Office sustains

a statewide campaign through its Minority and Multicultural Health Month, which is held annually in September. The Office is also charged with funding community-based organizations to conduct outreach screening and referrals in specific disease areas. In addition to partnerships with minority community-based organizations, the Office also partners with academic organizations such as the Center for Health Policy at Rutgers and the Institute to Eliminate Health Disparities at UMDNJ. The Office of Minority and Multicultural Health currently participates, also, in the New Jersey Hospital Association's work, which is focusing on language access and improving the ways that we collect race and ethnic data, in order to better track our progress in terms of addressing health disparities.

While the Office of Minority and Multicultural Health is charged with specific responsibilities, I also need to address the fact that the work of addressing health disparities is the work of the entire Department. Long-standing initiatives continue to reach vulnerable populations through outreach, education, comprehensive screenings, and referrals in several disease areas, including cancer, HIV/AIDS, asthma, arthritis, immunizations, infant mortality, diabetes, tobacco control programs. All of these programs target minority communities -- African Americans, Latinos, Asians, including the South Asian population. New Jersey grows continuously in its diversity. These are the populations who are hardest hit, as well as the fact that populations across all age groups suffer from disparities.

Increasing cultural competency is a critical component of all Department of Health and Senior Services health disparities initiatives. Most recently, the Department, within the Division of Senior Services,

enhanced its cultural competency programs that targets seniors as a way to help increase access to services that assist them in remaining healthy and independent within their own communities. For example, grants for arthritis, exercise, and education programs include requirements to partner with community-based groups.

HIV/AIDS continues to be one of the most challenging health disparity problems in our state. Tragically, almost 80 percent of all people living with HIV/AIDS in New Jersey are African American and Latino. At least one-third of those infected with HIV are unaware of their infection. Increasing and expanding availability of rapid HIV/AIDS testing is one of the ways that we are addressing this growing public health epidemic.

Rapid HIV testing is now available at over 140 locations throughout New Jersey. Since the first rapid test site opened in November 2003, over 45,000 people have been tested -- 70 percent of them are African American and Latino. The Department's aggressive mass media campaign targeting African Americans and Latinos is providing education, raising awareness, and encouraging use of rapid HIV tests.

African American and Latino children also suffer disproportionately from health disparities. An asthma collaborative is currently being implemented in New Jersey's Centers for Primary Health Care to ensure comprehensive, quality care for asthmatics -- this is a new initiative -- using a disease-management model established by the U.S. Bureau of Primary Health Care. This care model initiative includes multiple community partnerships which have established systems for tracking outcomes.

Through education and awareness campaigns that include the faith-based community, the Department is also working to prevent a growing number of minorities in all age groups from suffering from diabetes. We just implemented a new diabetes outreach program that focuses on community-based organizations, linking them with community partners.

While all children in New Jersey are at risk of lead poisoning, low-income, predominantly minority children living in urban areas are at the highest risk. For this reason, the childhood lead poisoning prevention activities of the Department particularly target these high risk areas. Using over $2 million of Federal and State resources, the Department aims to educate families on the importance of lead screening, ensuring appropriate follow-up, and inspections of homes of children with elevated lead levels, and promoting programs that will prevent lead poisoning. This includes the distribution of lead dust test kits to at-risk pregnant women so that they can test their home before a child is exposed to the dangers of lead.

On Monday of this week, the Department released a Spanish version of an educational video on lead poisoning as part of the Keep Your House Lead Free campaign.

As you said, Assemblyman, without-- Yes?

ASSEMBLYMAN PAYNE: Excuse me. Move the mike closer to you, please?

MS. HOLMES: Will that cut down on the ringing sound that I'm hearing.

MR. VARI: I hope so.

MS. HOLMES: Thanks.

Without access to quality health care, the battle against disparities will not be won. New Jersey continues to make progress in expanding its health-care delivery system for the uninsured and underserved in New Jersey. Over the past several years, a strengthened network of Federally Qualified Health Centers increased access to quality preventive and primary health care. During the next year, almost 100,000 new patients will have a medical home, through capacity building among previously existing FQHCs, and through the 10 newly established community health centers' access points.

In addition to access to quality health care, minorities also face challenges in accessing the prescription drugs that they may need. The uninsured and the underinsured are often forced to decide between paying for their basic living expenses or filling their prescriptions. Through Federal funding, Centers for Primary Care can offer prescription drugs at deeply discounted prices. New Jersey has two centers currently participating in the 340-B Drug Discount Program, making New Jersey the first state in the nation to commit resources to centers for pharmacy discount programs.

Even with these efforts that I've just outlined very briefly, we know as a Department that more can be done and more must be done. The Eliminating Health Disparities Act, which you referred to, charges the Office of Minority and Multicultural Health with developing and implementing a comprehensive and a coordinated plan to address where do we go from here. This mandate also specifically calls for establishing measurable outcomes and enhancing data tools to ensure a statewide assessment of the risk behaviors associated with health disparity areas.

To assist in reaching these goals, the Office of Minority and Multicultural Health recently applied and was awarded a small, Federal grant from the Federal Office of Minority Health for $148,000 per year, over a five-year period, to help build the infrastructure of the Department in terms of addressing health disparity areas. This grant permits the Office to tap academic resources and national experts to identify needs, develop training, and standardize data instruments to track outcomes. The OMMH received this funding in September of 2005. We are now in the process of conducting a health disparities self-assessment survey. Survey results will help us to extend best practices that strengthen our current disparities initiatives Department wide. Working with our senior staff and program experts to integrate best practices in addressing disparities in all programs throughout the Department, this plan will be comprehensive. It will address cultural competency, it will address specific disease areas, and it will also address data collection to address outcomes. The Department of Health and Senior Services hopes to complete this plan by the end of this calendar year. In developing the Eliminating Health Disparities plan, the Office of Minority and Multicultural Health will be very aggressive in inviting health-care professionals and advocates, to offer advice and counsel, to a series of statewide health connections meetings, which we anticipate will occur this Fall.

The Health Disparities Action Plan will address consumer issues through identifying ways to increase language access for populations who speak a language other than English. A recent national study published by the Agency for Healthcare Research and Quality reported a decline in the quality of hospital care for Latinos -- this was a nationwide

study -- and it suggested that without language access disparities increase. When patients and doctors don't understand each other, it is difficult for patients to comply with instructions and doctors are at risk for increased medical errors.

The New Jersey Health Disparities Action Plan will aim to improve access to translated materials and interpretation services. We will also do more to make health information available to the consumer at appropriate literacy levels and in multiple languages. Some of this information will be web-based to allow community-based organizations and faith-based groups to empower community members in taking control of their health.

In addressing risk behaviors, the Health Disparities Plan will identify ways to make health information available at appropriate levels. And one of the things that's important, we think, is that when people receive information that they can understand it. Some of this information will be web-based and easily accessible for dissemination by community-based and faith-based groups.

Over the past decade, in closing, there has been a watershed of information -- the Institute of Medicine's report on equal treatment was just landmark -- documenting what disparities exist and what can be done to address health disparities. Yet, as recently as last week, a study that was published in *Obstetrics and Gynecology* again demonstrated that even when there is access to prenatal care, African Americans continue to suffer the most when it comes to outcomes as it relates to infant mortality.

Some have called addressing health disparities the last frontier of the Civil Rights movement. The Eliminating Health Disparities Action

Plan, which our Office -- the Office of Minority and Multicultural Health -- is responsible for developing and implementing, will help us move forward as we aim to enhance our public health efforts in addressing this long-standing problem.

ASSEMBLYMAN PAYNE: Thank you very much. I appreciate your coming here to testify before us.

I have a tendency to be impatient. These disparities have existed for a long time. You say that you received funding for your Office, first, in 2001.

ASSEMBLYMAN STEELE: Two-thousand-five, the grant--

MS. HOLMES: Yes. I have to look -- 2001, I think, was when the-- We didn't actually get the funding in 2001. It was when the name of the Office was changed. We had funding for three years -- we've had funding for four years. The Office has funding for four years.

ASSEMBLYMAN PAYNE: Before this Office was established, what area took care of the minority disparities? Was there any programs that took care of this?

MS. HOLMES: Well, I think it's important to understand that addressing health disparities must be the work of the entire Department. Our Office is funded. We get $1.5 million a year for community-based grants, and essentially we're talking about less than 10 grants in communities. So what we're talking about when we talk about HIV/AIDS, when we talk about asthma, when we talk about lead -- we're talking about the poor of the mission of public health. And what we want to do with this Eliminating Health Disparities Plan is to really raise the bar in terms of

accountability and in terms of what strategies are being used by these health disparities initiatives.

For example, cultural competency needs to be better integrated into all of these initiatives. And we think that that can be done without additional dollars. We think that if we don't have good data in terms of measurable outcomes, we're not going to know whether these programs are really making a difference. We have mortality data, but that data is further down the line. What we want to know is, are these programs having an impact and making a difference in terms of reducing hemoglobin A1c levels, in terms of reducing the number of children that have to go to emergency rooms for care? And we think we can do a better job of that. And those are the things that this plan, which we hope to be able to deliver by the end of this year, will do.

ASSEMBLYMAN PAYNE: That's my concern -- that much of it is futuristic -- we will do this, we will do that. The problems have been here for a long time. And I hear what our plans are for the future, what we will do, and I was going to ask whether or not there's any empirical data. Are there any measurable outcomes now? I mean, we've been talking about this in the State of New Jersey, and around the country, for a long time. And now we're developing a plan that we will do certain things. There's no question about we cannot really change the situation unless we have empirical data. Has there not been any collection data -- you said mortality? That's at the end of -- that's at the end. That's how the people are dead.

MS. HOLMES: Right.

ASSEMBLYMAN PAYNE: Do we have the same kind of initiative to find out some of the things that contribute to the mortalities, some of the things that contribute to the illnesses, etc.?

MS. HOLMES: Let me just step back for a second. As you know, Assemblyman Payne, the issue of health disparities is very complex. Some of it can be addressed through health, but we also know that poverty, we also know that the uninsured, we also know that there's discrimination in the health-care system. So some of those things are not easily fixed by any one program or any one initiative.

On the other hand, one of the examples that I cited in my testimony is the rapid AIDS testing program that has been initiated within HIV/AIDS. This is a new initiative. It has received national attention. And we think that -- what we know is, if people don't know whether or not they're HIV/AIDS positive, they certainly can't do anything about it. We think this is one of the programs that is working. We think that increasing the number of Federally Qualified Health Centers, in terms of increasing access, is working. And there is data in terms of the numbers of individuals who are actually linked to services; the number of individuals who are tested, whether or not these tests were positive.

I think we have to continue to be aggressive.

ASSEMBLYMAN PAYNE: Yes.

MS. HOLMES: I think we have to continue to have these kinds of hearings, because it is something that Health, that Human Services, that Education all need to be involved in, not to mention community partners, advocates. It's tough. But that is not an excuse. I really think that if you give the Office an opportunity to revisit this issue

through this Health Disparities Elimination Plan, and an opportunity to actually really provide for input from communities-- We're not talking about a long timeline here. Oftentimes, people spend years developing plans. This is an action plan. This is a blueprint. And it is intended to build on what we are already doing. And that's why I spent time talking about existing programs.

ASSEMBLYMAN PAYNE: Yes. I'll allow just one other point. I guess we have to put a face on the statistics. I think people hear statistics, and it really does not impact. It doesn't carry over to actually-- When I talk about young people suffering from lead poisoning, whose brains have been damaged, who go to school and they have no cognitive abilities because the lead has destroyed their brain-- And so they go to school and there's no understanding of this. What happens is that people say, "Well, Johnny or Rashan," or whomever his name is, "is acting up in school. He doesn't want to learn," etc. Or the fact is that he cannot. And it goes on and on and on. We have thousands -- and we're going to deal with more about lead poisoning later on, on Monday. But we have to put a face on these things. We have to put a face on the people who need dialysis and can't get there. We have to put a face on this so that people don't just see this and walk away and don't do anything about it.

And the other thing, we have to convince the entire community that an investment in the minority communities or in the inner cities is an investment that impacts on the entire state. That if you invest in the beginning, we save money down the line. And so what we have to do in the Legislature is have all of our colleagues on both sides of the aisle say, "Although I live in," let's say, "Ocean County," or whatever, "this impacts

on me." Because if, in fact, we don't take care of these things in the beginning then we're -- all of us throughout the State of New Jersey, even on Island Beach, or whatever the heck it is, they're going to be impacted by it. And that's one of the things we have to do is invest on the front end of this thing. Need corporate partners, etc.

MS. HOLMES: Yes.

ASSEMBLYMAN PAYNE: One of the things, and I'll stop and let some other people speak. But for instance, you have -- we distributed, I think, lead testing things to-- I don't know whether we followed up on that. But women who were pregnant, I think, were given -- donated lead testing kits to check it out. I don't know whether that anybody ever did it, anybody really taught them to do that. I think we have to make sure that we follow through on these kinds of things.

And the last thing, corporate America -- tobacco smoking, etc. Tobacco companies target minority communities with--

MS. HOLMES: Yes.

ASSEMBLYMAN PAYNE: --very fancy kinds of advertisement. I brought to a budget hearing last year a beautiful neon sign. It was about this size (indicating), and it flashed. It had all the hip-hop artists on it. And it was telling kids that, "It's cool to do this kind of thing." And we need to make sure that we have the cooperation from the corporate community as well. We need to teach kids in school. Because I understand, in your north schools at least, you can't teach anything about sex education, that you have to teach abstinence. That the Federal Government only funds abstinence programs. Other kids just -- like Nancy Reagan used to say, "Just don't do it. Just say, 'No.'" But we need to teach

kids how to use condoms and things like this. If we have this HIV epidemic or pandemic going on, we need to teach -- we have to stop pretending that youngsters are not having sex. So we need to teach them where we have them, but they're not permitted to teach this. You know, abstinence. Anyway, those are my -- I guess you see some frustration on my part.

But one of the things I want to say is that all of us are impacted by this -- the Republican, the Democrats, the rich or poor, etc., etc., etc.

MS. HOLMES: That's right.

ASSEMBLYMAN PAYNE: So, thank you very much, and maybe some of my colleagues have some questions for you.

MS. HOLMES: Yes.

ASSEMBLYMAN STEELE: Mr. Chairman, thank you.

Ms. Holmes, you stated that the 340-B program -- we have two centers. Where are they located?

MS. HOLMES: I will have to get back to you with that information. Yes.

ASSEMBLYMAN STEELE: Okay. I would appreciate if you could give me that information.

I just wanted to just commend you on the work that you're doing. Certainly, health is important and it transcends any race, creed, or color. And I concur with the Chairman that when we make a person-- Preventiveness is far better than if we have -- or when it comes to repairs and everything else that we have to do. So I think we have to have an obligation to make sure that the educational partnership participates in every aspect, whether it's corporate America, our school system, or whether it's our faith-based initiative, because it's one of the areas that, sometimes

culturally, education has a problem. Because people who are -- have a problem, whether they think they're HIV affected, they don't have family support. So there are a number of things, barriers that's in place, that we have to break down to help people. And it's a difficult task. But I wanted to commend you on your commitment.

MS. HOLMES: Thank you. Thank you.

ASSEMBLYMAN BARNES: Mr. Chairman?

ASSEMBLYMAN PAYNE: Yes, Assemblyman Barnes.

ASSEMBLYMAN BARNES: A very professional presentation. I had a question on one of the comments that you made here in your-- You indicate that HIV/AIDS is one of the most challenging health disparities. In your study, can you make a determination or can you make a comment as to why there's so much HIV/AIDS? Any study done that-- My sense is that it's dirty needles. And I -- I don't know how other people feel -- I know that there are some people that are opposed to the bill, but I was one of the prime sponsors of the bill on the needle exchange. And I don't want to put you on the spot where you have to make a comment.

MS. HOLMES: Well, let me just say, briefly, as you probably know, Larry Ganges is the Assistant Commissioner for HIV/AIDS -- is a division that devotes all of its work to thinking about this issue.

The Assemblyman just alluded to the lack of education around the use of condoms. From the public health perspective, the Department has been very clear about, that there's evidence in the literature that indicates that clean needles can be a very practical strategy and has been demonstrated to be such in other areas of the country. But it's more than that. There's also the issue of education. There's the whole issue of

poverty and women being willing to make all kinds of compromises in the decisions that they make, and it's a sexually transmitted disease. So it's a very -- education, access to health care, and also just getting to some of the root issues.

ASSEMBLYMAN PAYNE: Excuse me?

Assemblyman Barnes, was your question about needle exchange, whether or not you guys support it or not, or what?

ASSEMBLYMAN BARNES: Yes. My sense -- I know that it's a controversial issue. I was one of the prime sponsors of the bill for clean needles. Because it kind of made sense if you're going to engage in that activity, it's nice to have a clean needle. And then one would also question whether or not most of the AIDS come from sexual activity or from the use of--

ASSEMBLYMAN STEELE: A syringe.

ASSEMBLYMAN BARNES: --needles.

MS. HOLMES: To answer your question as -- the Department has supported the use. We were supporting some demonstration projects in the state, as you might recall.

ASSEMBLYMAN BARNES: I know it's controversial in that--

ASSEMBLYMAN PAYNE: So the Department supports the--

MS. HOLMES: Supports, yes.

ASSEMBLYMAN PAYNE: Good. I was trying to get-- (laughter)

ASSEMBLYMAN BARNES: A lot of the-- Are you on board on that?

MS. HOLMES: You know, things change. (laughter)

ASSEMBLYMAN BARNES: Are you on board on that, Mr. Chair?

ASSEMBLYMAN PAYNE: I believe I am. If I'm not, I put it before me. Yes, I support that.

ASSEMBLYMAN BARNES: I know there was a bill that came up. There are a lot of people that think that by making the needles available you're increasing the use and so on. But it made some common sense. We've tried everything else. I don't see any reason why we can't try this. We can't regulate sexual activity, that's for sure.

MS. HOLMES: Actually, the Office supported clean needle exchange early on, even before the Department did. So, as the Director of the Office, we're very much in support of that public health strategy.

ASSEMBLYMAN BARNES: Thank you. It was a very professional presentation. Thank you.

MS. HOLMES: Thank you.

ASSEMBLYMAN PAYNE: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: In your testimony, you mentioned that the mission of your Office is actually a Department-wide initiative. And I agree with that. In order to be able to adequately do your job, perform your job, there has to be established, adequate interaction between your Office and all the various other programs within the Department -- for exchange of information, etc. -- as well as over in Human Services, Medicaid, and etc. Is this linkage well enough established within, in your opinion, or a little more needs to be done to ensure that you're well enough informed of what the other programs out there are doing, and that

they are informed at all to what you're doing? Is there adequate interplay between all the programs here?

MS. HOLMES: I am a member of senior staff. I do report directly to the Commissioner of Health. And I think that the Eliminating Health Disparities Plan and the small grant that we receive from the Federal Office of Minority Health will actually be a vehicle for the Office to be more involved with providing technical assistance on best practices and addressing health disparities. We are, currently -- the Office is conducting a self-assessment survey, which the Office will review. And then the Office, through a special health disparities work group of people in the highest level of the Department -- which did not exist yesterday, but will exist in the next couple of weeks -- will be the vehicle by which we will be able to have dialogue, with those initiatives throughout the Department, in order to help them to benefit from lessons learned around cultural competency, working with communities. And so I think that we are going in the right direction.

Commissioner Jacobs has been very, very supportive of the Office being more involved throughout the Department than it has been in the past.

ASSEMBLYMAN THOMPSON: From what you say, there sounds like that may be an improvement over the existing situation. You say you currently report to the Commissioner. That's good. But I think, for example, when we speak of HIV/AIDS, there needs to be a more direct link with that program, or with the lead program, or so on, so that-- Before something is a fait accompli, you know what's happening, you've been given some input there. And likewise, if you have something going, they can

learn about it -- the need to ensure that there's adequate interaction in order for maximum benefit to be gained from the overall program.

MS. HOLMES: I think it will be increasing.

ASSEMBLYMAN PAYNE: Thank you, Assemblyman Thompson.

This legislation was to take effect immediately. It was approved September 1, 2004. We're almost a year -- two years afterwards. I don't know whether or not there's any-- You mentioned now that you report directly to the Commissioner. Is serious attention given to this particular initiative, or is it lost in the maze? Do you really need -- has it been elevated to the point where it needs to be? Because we don't need to have this buried in the corner somewhere, and we don't need to just have testimony and speeches, etc. Is this division, of what you're doing -- is it regarded seriously in the Department? Because in the past, it wasn't. In the past, it wasn't. All right?

MS. HOLMES: Dr. Jacobs is very sincere when he says that addressing health disparities is the core mission of the Department. And he says it often. And to follow up with that, your question is, so what's being done that's making a difference? And what's being done now that wasn't being done before is that Dr. Jacobs has said that the Office will be developing this plan. But the Office will be developing this plan in conjunction with every division in the Department. That includes bioterrorism and it includes the regulatory component, as well as the areas of the Department that are involved with addressing specific disease areas. Because if it is not, then it is rhetoric to say that it is the core mission of the Department. So through this work group, the Office will be working very

closely with assistant commissioners, as well as senior staff, in developing moving the Department to the next level.

I just will welcome the opportunity at the end of this year to be able to showcase what it is that we have come up with that's different from what we're doing now.

ASSEMBLYMAN PAYNE: Good. Well, we certainly will hold you to that, because we want to see the measurable outcomes and the empirical data. And see, we need to see where the problems lie and what we can do about it, rather than just another study. I want to get this thing taken care of. You've said that it's been said that this is the last frontier of the civil rights fight, right? The last frontier of the civil rights.

The civil rights was accomplished-- After a while we became impatient with just the talks. Do we have to take to the streets? Do we have to get people to come? What do we have to do? We need to certainly bring greater attention to what you're trying to do, what we're trying to do. But if it takes some other kind of method of doing it, then perhaps we need to do that. Because there are too many people out there who are falling -- not just cracks, there's chasms. They're falling through and being forgotten, and we have to do something about it.

Thank you very much.

MS. HOLMES: I just want to say, in closing, if you don't mind-- I appreciate -- I respect your frustration, but I also appreciate your passion. And I think it's an opportunity for us to work together.

ASSEMBLYMAN PAYNE: Thank you very much.

Ms. Sheila Baynes, the Newark Emergency Services for Families. I must say, I really appreciate your being here. I know you had a

board meeting that you were to attend. I hope they're not firing you while you're out of there. (laughter)

S H E I L A T. B A Y N E S: No, no. The board is very much supportive of this work and felt that this was where I should be. And hence, here I am.

ASSEMBLYMAN PAYNE: Good. Okay.

Identify yourself for the record.

MS. BAYNES: My name is Sheila Baynes, and I am the Executive Director of the Newark Emergency Services for Families.

Good morning, Mr. Chairman, Committee members, and guests. My name is Sheila Baynes, once again, and I'm the Executive Director of Newark Emergency Services for Families, Inc., a 28-year-old social services agency serving over 67,000 needs per year throughout Essex County.

I appreciate the opportunity to share with you our perspective on eliminating health-care disparities, top conditions we are seeing, what we are doing as an organization, and some of our challenges, as well as our successes.

In Newark, home to an estimated 250,000 people in 2002, 53.5 percent are African American, 30 percent Hispanic, and approximately 25 percent of the adult population is living below the Federal poverty level. The percentages increase significantly when we talk about children. Poverty, as previously mentioned, is often a direct link to health-care disparities.

The majority of Newark and its surrounding Essex County have been designated as Medically Underserved Areas. Often ranking last or

second to last in major health-care indicators such as infant mortality; HIV/AIDS; breast, cervical, prostate and colorectal cancer screening; diabetes; lead exposure; and asthma.

Incidences of nonvaccinated children is very high in Newark, and although some progress has been made, there remains much to do. The same can be said for HIV/AIDS, with the largest growth rate among the adult population in the African American community.

Access to health care is a prerequisite to obtaining not only quality care, but consistent care. In the county of Essex, over the past three years, the past few years, major hospitals have closed in three different urban centers -- Orange Memorial in Orange, Irvington General in Irvington, and United Hospital in Newark. As of this testimony, there are several other hospitals which are struggling. With the closing of these facilities and the possibility of more, the access disparity will continue to sharply increase.

Newark Emergency Services for Families provides social services in a most unique way. We have five ports of entry into the Newark Emergency Services case management system.

Emergency Services Quadrant, which serves the working poor and those who find themselves in need of rental or utility assistance and other emergency needs-- It is here where we see trends. This is the cutting edge department.

The Homeless Services Quadrant serves the street homeless with a mission of bringing them indoors for eventual return to mainstream society. The clients have access to substance abuse counseling, a laundry facility, hot showers, and an opportunity for respite from the hard streets of

homeless life. This population is almost always in need of medical attention.

The Self-Sufficiency Quadrant, which is where, with the support of State funding, we work with General Assistance clients who are in their last months of welfare. And we help support moving these individuals from welfare to employment and self-sufficiency -- always the goal of Newark Emergency Services for Families.

And most recently, our health-care services, providing primary health care to the un- and underinsured. Additionally, we provide rapid HIV testing, as was remarked earlier, a vaccination project, and eye care. All who come to NESF have the opportunity to access the medical suite. And for those who prefer anonymity, we have a 24-hour hotline, seven days a week, where clients may call in and be directed to appropriate help.

In 2004, NESF and Newark Community Health Care Center (*sic*) -- a Federally Qualified Health Care Center (*sic*) -- and the city of Newark Homeless Health Care Project formed a partnership and opened our primary health-care suite in our social services facility. What we are seeing is a continued growth in people who do not have a primary physician and rely all too frequently on the emergency rooms of hospitals or who don't see a doctor until they are in the last stages of their illnesses -- illnesses that if caught earlier could have been successfully treated. All clients who come to NESF are asked, "Do you have a doctor? Are you in need of a doctor? Would you like to see a doctor?" Even though most people who come to NESF are not initially coming for medical care, they find that -- once they see our medical suite -- they make a much more permanent relationship with the health-care system. The doctors and

nurses are ethnically diverse and this reduces issues around language and culture.

Let me share a story with you. One of our clients came to us looking for rental assistance -- this is very much the norm and an everyday occurrence -- for him and his son. His wife had passed away a year earlier from AIDS and he, too, was infected. Unbeknownst to the child, he is HIV positive. Through our unique case management system, we were successful in finding them a home. The father did not have regular transportation to see his physician and was impressed to see a medical suite was available right in our facility. They chose to use our site and found that all of their medical needs could be met. NESF also has an after-school program and the son began to attend. Given his condition, he can access the medical staff when he is not feeling well, and his father is able to be comfortable in that his son's needs are being met. And at the end of all this, it turns out that the young boy is a math wiz. So it just puts a smile on your face.

I share this story because it gives you a true picture of what success in access to health care can and is doing.

Our approach is that everyone who comes to NESF will have access to health care and, hence, reduce the disparity. In our first full year of operation, the medical suite saw over 1,200 patients. An additional 400 had eye examinations performed. These are positives that we will continue to build on. Yet, there remain many challenges. Our concern about the decreases in Medicaid and the terrible impact it will have on our most vulnerable, especially the GA clientele, is at the top of the list. The lack of health-care insurance is growing, and many do not seek care due to the

embarrassment of their situation, especially the newly laid off and those not used to needing help.

We know that improvement is possible. When targeted, such as the Newark Emergency Services for Families model, health-care disparities can be significantly reduced. Significant investment in community-based providers meet the patient where they are, and therefore a regular relationship can be more easily established. Direct public education campaigns, such as videos for children and/or adults, as they wait for other services, may play an important role in reducing disparities.

In closing, I would like to leave you with two points that I hope will resonate with you as you continue to work to eradicate this problem. Point one: In the development and implementation of a plan to reduce health-care disparities between whites and racial and ethnic minorities, remember to look at what is working and to see that community-based partnerships, like Newark Emergency Services for Families, with Federally Qualified Health Care Centers, is seen as an opportunity for success.

Secondly, there are many socio- and economic advantages to this relationship, from the natural flow of clients who need access to health care, to the cost savings as a result of the combined efforts and services. In fact, the Federal Government has committed to an increase in funding to Federally Qualified Health Care Centers.

So in closing, again I thank you very much for giving me this opportunity to present my perspective on this critical issue, and I will be pleased to answer any questions you may have.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

I really do appreciate your being here today. I don't know whether any of my members have any questions or comments to make at this time.

Reverend?

ASSEMBLYMAN STEELE: Go ahead. Go right ahead.

ASSEMBLYMAN PAYNE: Let me just say this. I am extremely, extremely impressed with the work of the Newark Emergency Services for Families, NESF I guess it is -- very much. I visited it. I just happened to be in the neighborhood the other day, which is where the center is located, on Broad Street in Newark. It's a former -- I remember going there years ago. It was a nightclub, a dance hall. It was kind of a continental ballroom, which I had some pleasant memories about. But it's been converted into a place of hope. I've never been so impressed with a facility such as this in my life.

I think that what's going on in that organization should be replicated, should really be replicated in other parts of the state. I don't know whether it is or not, and I don't know whether you are, in fact, doing that. But when I walked into the place, just out of curiosity -- I had a few spare moments -- I listened as someone went to the window and was asking some information, etc., and they were helped. And I was there and they wanted to know if I could be helped. And I said, "Well, no, I'm just wandering around. And is the director in?" And anyway, they called the director, and I was invited up to her office. I took a tour of the place. I saw the place where homeless people can walk in off the streets and are given a shower and clothes. Where they are not told, "Well, go down the street."

"Come in here." And I'm just so very, very impressed. And the medical suite.

The fact that there are still people out there in the community and streets who are so destitute, have no place to go-- And my office has frequently called the Newark Emergency Services for Families, Inc. Folks can call all hours of night, "Where can I go? I have no place to stay." The hotline -- they can call, and go there and get a shower and a meal and get some rest, etc.

So what they're doing is really addressing the people who, as I said before, who we saw in New Orleans, for instance, when Katrina ripped the veneer of civility off the Big Easy. And we saw really what was going on and how people lived there. This organization is doing a job, I think, second to none. And you mentioned the partnerships. The partnerships that you have with other people. I have to say that I don't know what it is that -- I'm sure you probably have more money than you need. (laughter)

MS. BAYNES: Not quite. (laughter)

ASSEMBLYMAN THOMPSON: I would like to see the day when a poor person comes in and testifies that way. (laughter)

ASSEMBLYMAN PAYNE: Yes. I think that it's just an absolute center of hope, as I say, and to be able to be-- Tell us just a little bit, if you will -- example of some of the partnerships that you have established or are operating through your organization.

MS. BAYNES: Okay. And specifically, I'll address partnerships around the health-care issue. We have a partnership with UMDNJ. The Dean of Nursing, Dean Torres, is working to have a mobile health-care van available in the near future. We are working with her. And

we work with St. Michael's Hospital in Newark, and they perform our rapid HIV testing, which we just implemented within the last two, three months. And as mentioned earlier, we have our relationship with the Newark Community Health Care Centers, which is a Federally Qualified Health Care Center. And of course, the city of Newark's Health Department.

We work with a number of other social service agencies, churches in the area, and the law offices, the courts. Actually, we see referrals from practically everyone in Essex County. Because when people feel, "Well, where do I go? Where can I send this person? I really don't know what to do with this issue," typically they do come to Newark Emergency Services for Families. And if we cannot service them right at our center, we have partners and friends, and can refer them to other institutions for support. So we're busy seven days a week.

As the Chair mentioned, we actually were the base for the Katrina victims when they came into Essex County. And literally, we were working seven days a week, physically, at that point in time. We served over 130 people who came up from both New Orleans and Mississippi. So we're a very busy agency. We're doing, I believe, quality work. And I believe that we are making a sincere impact in reducing some of these disparities. And of course, with support in whatever form it comes, it's appreciated and it's needed. I think when you see a situation that's working, that's the horse to bet on.

ASSEMBLYMAN PAYNE: Yes, Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I commend you for the good work you do every day in servicing the people that are most in need of help.

MS. BAYNES: Thank you. Thank you very much.

ASSEMBLYMAN PAYNE: Thank you.

The 67,000 people that you serve I'm sure are appreciative of all that you're doing. I want to thank you very much for taking the time to come here to testify before us to give us an idea of just what's happening. Yours is a program that's working. It's not on the drawing board, it's working.

MS. BAYNES: No. It is working.

ASSEMBLYMAN PAYNE: Yes, that's great.

Thank you very, very much.

MS. BAYNES: Thank you.

Good afternoon.

ASSEMBLYMAN PAYNE: Excuse me? I just wanted to ask you one question, if you know. What, if you're willing -- what is your overall budget? What is your annual budget?

MS. BAYNES: Three-point-five.

ASSEMBLYMAN PAYNE: Three-point-five million.

Thank you very much.

MS. BAYNES: Thank you.

ASSEMBLYMAN PAYNE: I see Assemblyman Stanley is here.

Assemblyman Stanley, would you care to testify? Are you here to testify?

A S S E M B L Y M A N C R A I G A. S T A N L E Y: Yes, please.

Thank you. And before--

ASSEMBLYMAN PAYNE: On this issue? This is on this issue, correct?

ASSEMBLYMAN STANLEY: Yes, absolutely. Well, yes, of course.

ASSEMBLYMAN PAYNE: Well, I mean, my Vice Chair just happened to raise a question whether or not it's on this issue, and I--

ASSEMBLYMAN STEELE: I know he's so diversified. I didn't know which direction he was going, Mr. Chair. (laughter)

ASSEMBLYMAN PAYNE: Sure.

ASSEMBLYMAN STANLEY: But I'm sure the Vice Chair or the Chair will rule me out of order if I'm not on the issue. (laughter)

ASSEMBLYMAN THOMPSON: (indiscernible)

ASSEMBLYMAN STANLEY: Let me just -- let me start by commending Newark Emergency Services for Families, Incorporated for their work. I think you're very right to point out how good a job, how well they're working in the community, how good a job they're doing. And I know they know my staff very well -- Dave Garry, probably, on a first-name basis -- because we do have a lot of need in those areas. And one of the things that I must commend Newark Emergency Services for Families for is the way in which they provide for people. They treat people with dignity, with respect. They respect people's privacy. The facility is one in which you wouldn't know that you were going into a facility that provided services to the homeless and the downtrodden, and etc. It is a first-rate facility. I was there for their groundbreaking and their renovations and everything else.

And actually, Mr. Chairman, my generation knows that as the former Paradisio. It was a ballroom before it was the Paradisio.

ASSEMBLYMAN PAYNE: I was at Paradisio when they opened up -- the grand opening. Okay, thank you very much. (laughter)

ASSEMBLYMAN STANLEY: Yes, that's right. Hey, I know you were. (laughter)

ASSEMBLYMAN STEELE: Let's stick with the subject, please. (laughter)

ASSEMBLYMAN STANLEY: And I agree, and I'm glad you brought this issue up, because you're known as the bulldog of the Legislature. And any issue that needs to be dealt with that hasn't been -- when it comes before your Committee, most people figure that there will be some movement on the issue going forward.

ASSEMBLYMAN PAYNE: Pit bull, and not bulldog. Pit bull, get it right. (laughter)

ASSEMBLYMAN STANLEY: Oh, okay. All right. Okay. The pit bull, I stand corrected.

The one issue that I did want to raise was the issue -- and I think the Executive Director brought it up a minute ago -- and that was the closing of hospitals in urban areas. We talk about the disparities. However, in the very areas where you have the greatest disparities, you have the closing of hospitals. Since 1996-- Irvington General has been closed. It was just closed recently. And probably one of the most, the neediest from a health-care perspective -- one of the most neediest communities in the state -- has had Irvington General closed. And that, as we know, many of these people go to the emergency rooms, to these hospitals, for primary care. They don't have any insurance and they go in for primary care or when an

emergency arises -- a sick child, or whatever. And this is something that's even more negatively affected, the health disparity.

I just wanted to bring up West Hudson Hospital, Passaic Beth Israel Hospital, the Hospital Center in Orange, Elizabeth General, St. Francis in Jersey City. And this is wrong. And I've introduced a bill, Assembly Bill No. 2691, and that bill actually places a moratorium on the closing of hospitals in areas where you have high incidences of morbidity. So we're hoping to push that bill, because there is not a real comprehensive health-care strategy in the State of New Jersey. And I think that's what you're exposing here. And the fact of the matter is, the disparity will continue to grow because insurance is becoming less and less accessible to people in need.

The other issue is what happens in the case of a catastrophe. I raised this issue with one of the presidents of one of the major health corporations in the state. And the issue of a natural disaster, such as what happened in New Orleans; the issue of, perhaps, a biological disaster, such as bird flu or some other medical issue that becomes rampant, becomes an epidemic; or even the issue of an emergency -- of another 9/11, of an act of terror -- what would happen in the areas where you have the poorest people? And the answer was not very comforting, Mr. Chairman.

And so we have to make sure that we preserve these facilities. Because in the event of an emergency, if we don't preserve these facilities before we have an actual blueprint, an actual master plan, a contingency plan, what will happen is, these facilities will be leveled. They'll be other things there. And then when we need them, in a case of an emergency, we

won't have them available. So that is another issue that we have to think of, that we have to look at.

The current way in which we grant certificates of needs for closing hospitals does not work. Because in many cases, urban areas where you have people who are not able to pay as they go -- don't have insurance, uninsured people, people who don't have the wealth to pay for their services -- these hospitals are put in an at-risk type of situation just like the people. The hospitals become at-risk. And so what happens -- Irvington General, which was struggling, was bought by Barnabas. But then the different services that Irvington General provided were eventually moved out to other facilities within the Barnabas system, perhaps. And then what you were left with was a shell that could not sustain itself. And so it becomes a bottom-line scenario for Barnabas to close Irvington General. Well, the problem is, is that health access should not be a bottom-line issue. It should be an issue of need. It should be an issue of providing for the citizens of our state. Because as a State, we're required to do that.

The second issue that I wanted to bring up was the issue of gang violence. Gang violence. And I know it sounds like, well, is this on the issue? But as a matter of fact, a child or a person, a male, an African American male, age 15 to 35, is more likely to die from violence than any other cause. And that is astounding. And that's a health disparity issue.

If we look in our emergency rooms -- and that's just dying. That's not wounds and everything else. But the cost associated with that is incredible. I just talked to Assemblyman Barnes on the way out about the Gangland Task Force -- you know there's a statewide Task Force -- and I have been working with the University of Medicine and Dentistry to look at

ways in which we can bring this to the fore and actually promote it to a national issue. Because gang violence, as you know, doesn't just affect New Jersey. It's becoming an issue that's affecting the suburbs. And it's not affecting just African Americans, but it's effecting people all across the board.

ASSEMBLYMAN PAYNE: Mr. Stanley, you brought up a number of things. One is, you say you have a piece of legislation proposed, A-2691. Does that deal with developing a comprehensive health-care strategy, or what? What does that do?

ASSEMBLYMAN STANLEY: Yes, sir. It deals with -- well, it actually provides for a moratorium on the closing of hospitals in the areas--

ASSEMBLYMAN PAYNE: Okay.

ASSEMBLYMAN STANLEY: --that have high medical need.

ASSEMBLYMAN PAYNE: You brought up -- we have another person to testify, and also we have another topic we have to get into as well. But I just wanted to be very specific.

ASSEMBLYMAN STANLEY: Sure.

ASSEMBLYMAN PAYNE: We bring up a lot of these problems and we need to have -- for instance, your legislation deals with a moratorium on closing hospitals.

ASSEMBLYMAN STANLEY: But it also provides that before any other hospital can be closed, that there is a comprehensive strategy to deal with comprehensive health strategy.

ASSEMBLYMAN PAYNE: Oh, is that part of the bill?

ASSEMBLYMAN STANLEY: It's part of the bill.

ASSEMBLYMAN PAYNE: Okay, good.

ASSEMBLYMAN STANLEY: And also provides for contingency plans in the case of emergencies -- biological, natural, and terrorist.

ASSEMBLYMAN PAYNE: Okay, good. Well, thank you very much. Just some very specific things that we can look for in your legislation, and we can certainly debate. And hopefully, we'll be able to take some action on it soon. And the gang violence is an issue that permeates the entire society, and we certainly need to find something to do about it. Really, the bottom line is poverty. Poverty is at the bottom of all this stuff. Poverty is the fact that the people do not have decent nutrition in the schools. Poverty is really at the base of so many of the problems that we're talking about.

But thank you very much for taking the time out to testify.

ASSEMBLYMAN STANLEY: Thank you, Mr. Chairman. I appreciate you giving me an opportunity to testify.

ASSEMBLYMAN PAYNE: Thank you.

Ms. Diane Brown, University of Medicine and Dentistry.

D I A N E P. B R O W N: Good morning to Assemblyman Payne and to the other members of the Committee and guests. My name is Diane Brown, and I'm Executive Director of the Institute for the Elimination of Health Disparities at UMDNJ. We are physically located in Newark, and administratively with the UMDNJ School of Public Health, although we are involved in activities statewide. We were established in 2002, and our broad goal, basically, is dedicated to leadership, research, education and training, and community outreach and advocacy for the elimination for health disparities.

I'd like to thank you for giving me the opportunity to talk with you about health disparities in the State of New Jersey, specifically to address the health disparities characterized by the greater morbidity and mortality enjoyed by members of the State's racial and ethnic minority groups. I'm also happy to say that we have partnered with the Office of Minority and Multicultural Health, and I'd like to commend Ms. Holmes and that office for their work.

The existence of health disparities is an important issue for our State, given the significant and diverse racial and ethnic minority populations, approaching 30 percent. There is evidence that some progress has been made, although we know there is much more to do. And I'd just like to highlight several of those areas that we have focused on.

With regard to maternal and child health, there's good news. The good news is that the infant mortality rate in New Jersey decreased among all racial and ethnic groups between 1993 and 2003. However, the disparities continue with black mothers having more than twice the rate of infant mortality than any other group. Also, access to prenatal care in the first trimester has improved overall between 2000 and 2003. But again, the disparities among minorities remain high.

With regard to asthma, the data have not moved in a positive direction, specifically with regard to hospitalizations, which we know brings about an unnecessarily costly way of managing the disease. Over a recent five-year period for which there are data, the asthma hospitalization rate has increased for all groups, but it's particularly high with blacks being hospitalized at a rate that's four times that of whites.

Similarly, with regard to obesity--

ASSEMBLYMAN PAYNE: Excuse me? I missed that. Say that last statistic, please?

MS. BROWN: In terms of asthma, blacks are being hospitalized at a rate that's four times that of whites. And it's due primarily to the lack of primary health care, and also to lack of management of the disease.

ASSEMBLYMAN PAYNE: Four times greater than whites. Is it because blacks live in areas, for instance, where there is a higher level of diesel fuel, for instance, being used -- buses, etc. -- and in urban areas? Does that not contribute to some of the asthma attacks?

MS. BROWN: Environmental exposures do contribute. Also, older housing may have aspects that also aggravate risks for asthma as well. Because we know that many of our populations live in inner-city, older homes.

ASSEMBLYMAN PAYNE: So it's not because they are African Americans? It's because of the condition, the environment in which they reside. Is that correct?

MS. BROWN: Oh, yes, definitely.

ASSEMBLYMAN PAYNE: So if, in fact, the white folks living in those same areas -- would they be impacted in the same way?

MS. BROWN: Well, yes and no. They might be. But then, one is also impacted by access to health care and also being able to manage the disease. If you have access to health care, then you're seeing a doctor, and you're engaged in managing the asthma.

ASSEMBLYMAN PAYNE: So that figure was what? Ten times -- what was the figure there?

MS. BROWN: Four-to-one. It's four times higher for blacks, in terms of asthma hospitalizations.

ASSEMBLYMAN PAYNE: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: She's saying the hospitalization is four times. What is the -- I know there's a higher incidence of asthma among blacks, as opposed to whites. What's that ratio, the incidence rate, not hospitalization simply?

MS. BROWN: Okay. I don't have it here, but it is higher, too.

ASSEMBLYMAN THOMPSON: Now, the question is, whether this is the same proportion as the admission rates.

MS. BROWN: No, it isn't. But the ER, hospital rate for asthma is higher for blacks than it is for whites.

ASSEMBLYMAN THOMPSON: Well, yes. But my question was, how does it compare with simply the incidence rate of asthma of blacks versus whites?

ASSEMBLYMAN PAYNE: There are four times as many blacks that are being hospitalized for it. Are there others out there that are not being hospitalized, number one; and number two, what is the percentage of whites that are there that are not being hospitalized there? We're talking with the figures you show and not who has asthma, but who has been hospitalized for asthma. I think that's what you're--

ASSEMBLYMAN THOMPSON: And there is a higher incidence rate of asthma among black versus white--

ASSEMBLYMAN PAYNE: Right, yes.

MS. BROWN: Right.

ASSEMBLYMAN THOMPSON: --whether these are in proportion or not.

MS. BROWN: Okay. I don't have it here right in front of me, but I can certainly get the data for you.

ASSEMBLYMAN PAYNE: Could you, please? Yes. The thing that I'm concerned about is whether or not there's something genetic about blacks, or is it, as I've said, the environment in which they--

MS. BROWN: It's more environmental.

ASSEMBLYMAN STEELE: It's environmental. The location, location.

MS. BROWN: It's environmental. It's poverty. It's environment. It's exposure. It's access to health care and access to drugs that will help people manage asthma.

ASSEMBLYMAN PAYNE: Yes. Well, my thing is prevention, if there's such a thing. For instance, in the inner cities around the schools, the school buses themselves spew out diesel fuel--

MS. BROWN: Right.

ASSEMBLYMAN PAYNE: --and it's one of the things that can be stopped. But it's just overlooked. I mean, buses pull up and they sit there, but it's just-- It's overlooked. Buses pull up, and they sit there, and they-- So kids in the area are exposed to that. You go up and down certain corridors in urban areas, like Newark, where the bus routes and the truck routes -- they're spewing out these fumes. That's why we have to try and do some clean air stuff. Because it is the dirty air that's causing this. And it's a simple thing like school buses taking kids to school, sitting there with

spewing out these things for a half hour while the motor is running. Those are kinds of elementary things that seem to me that people should point--

ASSEMBLYMAN THOMPSON: I think we've passed legislation prohibiting them from sitting there with their--

ASSEMBLYMAN PAYNE: Idling, yes.

ASSEMBLYMAN STEELE: That is correct. It is against the law, whether it's a bus or 18-wheeler.

ASSEMBLYMAN PAYNE: Well, we need to report some of these people that are doing it, because they're still doing it.

I'm sorry, continue.

MS. BROWN: The point I was trying to make is that things haven't improved in that regard.

ASSEMBLYMAN STEELE: Sure, yes.

MS. BRONW: And that's an area where we need improvement. Diabetes and being overweight is also another area where we need improvement. Because the data show that diabetes disproportionately affects ethnic and racial minorities. In 2004, blacks had the highest adjusted prevalence rate of diabetes at almost 12 percent, followed by Latinos at 7 percent, and whites at 5 percent.

Also, overall, the percentage of New Jersey residents who are obese has increased -- so we're all getting fatter -- from 2000 to 2003. In 2000, 25 percent of blacks were obese. In 2003, for which we have recent data, it's almost a third -- it's 32.5 percent of African Americans in the state are obese.

ASSEMBLYMAN PAYNE: Why?

MS. BROWN: Why?

ASSEMBLYMAN PAYNE: Why?

MS. BROWN: I don't know if I have the answer for that. It's multiple factors. It's again, I'd say, in part attributable to health-care access, but it's also nutrition, access to recreational facilities, especially in the inner city areas. Also in many of the inner city areas, exposure to fast food places that are often high caloric foods.

ASSEMBLYMAN PAYNE: There have been some recent studies that say that it could be genetic. That there is a genetic predisposition for obesity in some people. I have heard that there are some studies that say that. There is a genetic cause of this -- and I don't know what that means. It means you have a bigger appetite or what have you. Have you heard of any recent studies along those lines at all about--

MS. BROWN: Not in terms of tying it to African Americans or a particular racial group. I think that there are data that link being overweight to biological and genetic reasons. But I haven't seen anything that links it, specifically, to being black or any other race.

ASSEMBLYMAN PAYNE: But then it could be hereditary in some instances?

MS. BROWN: Yes.

ASSEMBLYMAN PAYNE: I ask why, because it's one thing to have a lot of testimony about different kinds of things, etc., but I want to find out what's the cause of it, for instance. Is it more obesity among blacks -- why? -- because of their environment, because they're living in places where there's fast food, etc.? If you take poor whites who live in the same kinds of conditions, will they also be obese as well?

MS. BROWN: Yes. It's also associated with poverty, as well as culture and health behavior habits.

ASSEMBLYMAN STEELE: Absolutely.

Mr. Chairman, I think that may certainly play a major role in the whole education component of what we call a *happy plate*. That we believe we've got to eat it all. If not, it's not a good meal. Proportions, which we need to discipline; to walk, to exercise. We have young people who are actually failing their physical education. We should be a class that easily pass, but we have a society that's not participating in good judgment, along with all the other things that could inhibit the process.

MS. BROWN: It's also related to stress. Comfort food is often very fattening food. And a lot of us are under stress in our lives.

ASSEMBLYMAN STEELE: Yes. Sure, sure.

MS. BROWN: The other area I just wanted to touch on briefly deals with cancer, particularly prostate cancer. And the good news there is that the rate of new cases has declined from 1999 to 2000 for both African American men and for white men. However, we have significant disparities that continue to exist in African American men in New Jersey -- have the highest rates of prostate cancer in the nation. And Essex County is a particular target.

And I just want to talk a little bit about the issue that we are addressing. We have been partnering with New Jersey (indiscernible) and University Hospital to implement a continuum of education and outreach and care, such that there should be no African American men in Newark who are not accessing screening. We are offering free screening to any man, although we're targeting African American men, for prostate screening. And

if they are found with abnormal findings, they will be shepherded through the system for treatment, whether or not they have health insurance. Needless to say, we have not been overrun with men desiring to get prostate screening. So that's a charge that we have.

ASSEMBLYMAN PAYNE: Why? Why not?

MS. BROWN: That's what we need to find out. Because there is no reason, right now, that one should not be screened, and gone through the diagnostic process, and be treated in the city of Newark.

ASSEMBLYMAN PAYNE: Thank you.

Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: You give a great deal of statistics there with regards to a comparison of black and white. But of course, in the Newark area, you have a very substantial Latino population. How do the figures for the Latinos tend to come up?

MS. BROWN: Okay. They are not as high as they are for black men. I do have those data here, back at my seat. So we haven't started to target Latino men. We're starting first with African American men, because that's where the greatest number is.

ASSEMBLYMAN THOMPSON: Well, I relate to all -- especially when you spoke of not just men. You were talking women, children, etc. For example, obesity figures and other things. I'm not just relating to prostate cancer. I'm saying of the various categories you spoke of. I know statistics generally indicate the Latinos have higher rates of these problems than the white population as well.

ASSEMBLYMAN STEELE: That's true.

ASSEMBLYMAN THOMPSON: And I'm just wondering how they compare in your particular service area -- the Latinos with the blacks?

MS. BROWN: Okay. Well, there are two issues here. I was trying to relate some indications of change in health disparities over time. And so that introduces the whole problem of, do we have sufficient data on Latinos? That's only been in recent years that we've gathered more data on Latinos. With regard to some of the conditions that we have talked about, being overweight and diabetes, that's an area where Latinos have a higher prevalence rate. With regard to cervical cancer for Latino females, that's also a problem, as well as some of the other cancers. I believe stomach cancer is also at a higher rate for Latinos.

ASSEMBLYMAN PAYNE: Maybe diet has a lot to do with that, I'm sure -- the spicy foods.

MS. BROWN: Yes, with stomach cancer.

ASSEMBLYMAN STEELE: Mr. Chairman, I would ask -- Ms. Brown, if you could make that written testimony available to us, we'd certainly appreciate it. I know you have some data there.

MS. BROWN: Right. I was trying to actually shorten my presentation.

ASSEMBLYMAN STEELE: Okay, yes.

MS. BROWN: I have all of it on (indiscernible) with me.

ASSEMBLYMAN STEELE: Well, I'd appreciate it if you can get copies of them.

MS. BROWN: Well, I certainly would like to.

ASSEMBLYMAN PAYNE: We'd like copies of what you're--

MS. BROWN: I really have one major point I wanted to make. I'll just reiterate what other people said about HIV. It's at a critical point in our community, and the disparities are going in the wrong direction there, particularly with regard to black women. Access to health care -- we know that the numbers of insured are decreasing. In 2001, 22.4 percent of blacks were uninsured. It's increased to 25 percent. That doesn't seem like a lot, except if you actually talked to people who are in that increase and how it has affected them. Among Hispanics in 2001, it was 33 percent. Now it's 38 percent of Hispanics in the State of New Jersey are uninsured. Also the percentage of children under the age of 19 without health insurance seems to be increasing. And I can provide those data, too.

So the question is, what are we doing about these health disparities that exist? Clearly, not enough. We've had accounts here of activities and efforts that are taking place. I do not think that they are enough. I think that we need to cast a wider net. I'd also like to say that we can't just put the responsibility on the Office of Minority and Multicultural Health and the New Jersey State Department of Health and Senior Services. It needs to go beyond that.

I'm also very frustrated about this. I think that we need to ensure that our elected officials and our business community understand that health disparities are not just a minority problem, but that continuing inequalities in health status and inequality in access to quality health care have ramifications for all of us, for our employers and for our government. And we need to be sure that we all understand the impact of health disparities on all segments of our economy, so that we need to bring in the

department that deals with environmental affairs, housing, employment, recreation, public safety and transportation. It's not just a health issue.

Sure, it's a matter of money and resources, but also it's one of having the collective will and desire to bring about change. So with that, I want to thank you for taking the time and for inviting me. And I will provide you with the backup data.

ASSEMBLYMAN PAYNE: Thank you very much.

Before you leave, Assemblyman Thompson would like to ask you--

ASSEMBLYMAN THOMPSON: Again, what did you say your title is with UMDNJ?

MS. BROWN: I'm a professor of health education and behavior science in the School of Public Health, and Executive Director of the Institute for the Elimination of Health Disparities.

ASSEMBLYMAN THOMPSON: You presented a number of statistical bits of information here, but maybe I missed it. I didn't hear what UMDNJ is doing, aside from compiling data, to attempt to deal with eliminating disparities.

MS. BROWN: Okay. Actually, I'd be happy to provide you with a publication. We are an academic institution. It's a publication that the Institute has developed in conjunction with the Hispanic Center of Excellence, in which it lists many of the activities that the UMDNJ faculty are engaged in towards the elimination of health disparities. And it covers projects that deal with lead poisoning in Newark, to environmental projects and asthma projects in Camden, as well as projects in New Brunswick. And that provides a nice summary. But it is an integral part of what UMDNJ is

supposed to be doing as a State institution. And part of what the Institute is contributing to is to facilitating and motivating faculty to do work in the community that is directed at the elimination of health disparities.

But we're involved across the board.

ASSEMBLYMAN PAYNE: Thank you very much for your testimony, and we will look forward to receiving some of the data that you stated today.

Thank you very much.

Just one question for Ms. -- Linda. What is the budget of your Division or Department?

MS. HOLMES: (speaking from audience) For the Office?

ASSEMBLYMAN PAYNE: With funding for your--

MS. HOLMES: Specifically for the Office, it's 1.5 million.

ASSEMBLYMAN PAYNE: One-point-five million. And how many employees do you have working with you? The budget for your Division?

MS. HOLMES: Okay. I was thinking -- I almost went to lunch.

One-point-five million is the total budget for the Office. We have five professional staff and two supportive staff. The majority of the dollars go to community-based organizations for outreach education activities.

ASSEMBLYMAN PAYNE: All right. For the record, that was Ms. Linda--

MS. HOLMES: This is Linda Holmes, Director of the Office of Minority and Multicultural Health.

ASSEMBLYMAN PAYNE: Thank you very much.

ASSEMBLYMAN THOMPSON: So the 1.5 million covers what the cost is for salaries and so on. Plus, all of the moneys that you might have available for giving grants, as well.

MS. HOLMES: That's correct.

ASSEMBLYMAN PAYNE: Thank you very much.

That concludes this portion of our hearing on disparities.

And we're going to now have a hearing on the Sudan divestiture legislation. Just give us about a two-minute break. I have to discuss--

And I'm going to hear from the representatives from the Darfur Rehabilitation Project first. Okay?

We'll be right back.

(RECESS)

AFTER RECESS:

ASSEMBLYMAN PAYNE: Good afternoon.

We are meeting today to receive an update on the situation that is existing in the Darfur region of Sudan. As you know, our Sudan divestiture bill, which was introduced in January of '05 and signed into law by Governor Codey in August of '05--

And the purpose of the legislation, as we all know, was and is to begin the reversal of the brutal, horrific crimes of genocide being perpetrated by the Khartoum government in Sudan. This legislation would require the New Jersey Division of Investment to divest the State's pension

portfolio from foreign companies with ties to Sudan. The purpose of our legislation is to encourage similar action across the country and in other nations, to pressure Sudan to halt the crimes against humanity which are going on there. Unfortunately, we have recently witnessed an increase in the heinous brutality against the citizens of the Darfur region of Sudan.

We cannot be silent on this matter. We cannot, and must-- We can, and must, bring a halt to the evil acts of the Jinjaweed, the instruments of death and destruction in Darfur.

Let me make it clear that the action we took last year to begin divestiture was not simply a symbolic act to be forgotten and ignored. No, no, we are serious about this initiative. And you can be sure that we will insist that New Jersey lead the way.

Although the Treasury initially opposed this legislation, and called it *poor fiscal policy*, we were able to get this legislation passed. We reminded that office that the money that was being earned on our investments were dripping in blood. Our initial information indicated that New Jersey had some $4.8 billion invested in the companies that were doing business in the Sudan. However, we have been informed that the figure is much less. Whatever it is, it is too much. And we expect to receive an update on the status of this legislation and this initiative today, and in the next several days.

I might add that many colleges in the United States have divested. And a number of other states, including Illinois, have divested, even though New Jersey was the first to implement this legislation. It is my understanding that Illinois has divested its very complicated funds they

have -- index funds, etc. But they have divested up to $8 billion, as of January -- $8 billion. So at least it's working.

Before we hear from the Treasury, we would like to hear from representatives from the Darfur community, from the Sudan community. Unfortunately, the conditions of genocide have recently become much worse. The Jinjaweed have been unleashed again; and the rapes, the burning of villages, the slaughter is again widespread. Blood is, once again, flowing in that region.

Before we hear from the Department of Treasury, I would like to invite representatives of the Darfur Rehabilitation Project to give an update on the situation in the Sudan.

First, I would like to ask Mr. Abushanab, from the Darfur Rehabilitation Project, to please come forward to give us an update.

And pronounce your name for the record, please.

A B D E L B A G Y A B U S H A N A B: Good afternoon, ladies and gentlemen.

My name is Abdelbagy Abushanab. I am the President of Darfur Rehabilitation Project, proudly headquartered in the city of Newark, New Jersey.

Thank you, Mr. Chairman, members of the Committee, guests. First, I think it is a must for me, as a Darfurian -- even though I stay here as a U.S. citizen -- to thank this State, through many goodhearted people who spent some sleepless nights, some restless days, to make sure that their fellow human beings -- even though tens of thousands of miles away from here -- get relieved from the painful -- actually atrocious actions by the government that is actually -- it is their duty to protect them.

This past February marked the third year of continuous genocide on the innocent people of Darfur. In those three years, we lost nearly half a million of our community members. Nearly 300,000 were forced to cross the border -- in many cases walking on barefoot -- to make it to the other side of the neighboring Chad, where they're living in horrible conditions. We must thank the world community for it's contribution in many areas: health, food, protection to a limited extent. And yet, the genocide goes on.

In (indiscernible), nearly 3 million were forced out of their lands. They live in what's called *terminally displaced camps*, where the living conditions are so horrible that even the world community are working with those terminally displaced people. After three years we have returned. Now in this place of broken pieces -- does not provide any shadow, it does not provide any protection from the sun or the sandstorms that hit. So the situation is not getting better.

Many resolutions from the United Nations Security Council regarding this issue were simply ignored by the government, that has no respect for the world body -- forget about the people it is supposed to protect.

Considering the time -- and I'm sure you have other duties for the rest of the day to do -- I just want to say that we were encouraged, in the recent weeks, when our President, President George Bush, took major steps -- I consider them -- in addressing the issue brought forth, by showing his support to have the NATO forces provide some logistical support for the Blue Helmets that are expected to arrive to protect the civilians, and also

facilitate some sort of peace process that will at least (indiscernible) the region, and have our people go back to their lives.

To be very honest with you, the way it looks-- It doesn't look like there will be a solution in the near future, because after the successful meeting-- I call it successful, because this was the first time the U.N. Secretary-General Kofi Annan and U.S. President discussed -- and both supported -- having NATO and the United Nations' peacekeeping forces go to Darfur and take over the mission from the AU forces, whose mission nearly did not do enough to bring some relief and stability to that region.

Yet, as we saw for the last 10 days to two weeks, the entire Arab world, plus China and Russia, went through a very fierce campaign to make sure-- Sudan's purpose, and it is supported by the other Arab nations, is to make sure the Blue Helmets or NATO does not make it into Darfur.

Yesterday, Sudan witnessed the remobilization of what is called the so-called Popular Defense Forces. These are the militia groups of the government used in the southern part of Sudan to kill about 4 million people in the last 22 years. Now that they know the solution is about to come to save the lives of the Dafurians who are X-marked for elimination -- now they are trying to remobilize the same people to resist. This is a signal to the world community that-- And, actually, some of the signs that we carry -- that if NATO or the United Nations -- these forces -- make it Darfur, Sudan will turn into Somalia. And we know what happened in Somalia.

So I think it is very important to use other pressures, such as the divestment, where we all know that changed things dramatically a few years ago in South Africa. And I'm sure it will work.

This is a state where I take pride in being a resident of. It's in the forefront of helping the people of Darfur and Sudan, in general. It is absolutely important to support and make sure that this goes-- Some people talk about -- "Well, it's not that much money," but I think even a penny makes a difference. It makes a difference. And we cannot say enough to thank the communities, the community leaders, and the government of this State.

Today, as we're trying to celebrate, like I said, the new (indiscernible) of the arrival of the real help to the crisis in Darfur, we are faced with another danger, where other possible worlds are saying simply, no. I'm sure you know China has an interest in Sudan. Russia has an interest in Sudan. The Arab world has an interest in Sudan, because actually why Darfurians are being targeted is because their land has been promised to the Arabs to come and resite. That's why the actions are so atrocious. When a village was destroyed, or a community was attacked, the damage was to the extent that these people go one way, never to come back again. That was intentional.

Though my colleague Yahya-- And I forgot to mention that I'm accompanied by our Secretary-General, Yahya Osman; and also our Executive Director, Blanche Foster. She is an American. She is not from Darfur. She put her heart out like many of you did for the poor people of Darfur.

When you talk about things like NATO, we do not talk about people to go there, or military to go there and fight a war to stop it. I know that the situation in Darfur is such that a political will from the United States -- a few words will change a lot of things for us. The government of

Sudan takes pride in being entirely supported by the government of the United States. That's why it does not respect the resolutions of the United Nations. And now they threaten to destroy, or postpone, or actually prevent any attempts to save the lives of people who have been dying for the last three years.

So I want to stress a little bit more that the divestment is very important, and it affects, in many cases -- resulting in, actually, a lot of positive things. And we can take as an example what happened in South Africa. I don't think it was the decision by the political circles around the world that changed things in South Africa. But it was a government that was falling apart, because it lost its financial support from the world community. That is how powerful the divestment is.

I'm sure there are other critical issues, but my colleague Yahya Osman is the person who is in daily contact -- and also who took a trip to visit most of the refugee camps in Chad. And he makes frequent calls, almost on a daily basis, to see what the situation is. And I hope he can update you on the refugee situation, and the IDP camps, and also the refugee camps in Chad.

Thank you very much for listening.

ASSEMBLYMAN PAYNE: Thank you very much.

If Mr. Yahya--

Y A H Y A O S M A N: Good afternoon.

My name is Yahya Osman. I'm the Secretary-General for the Darfur Rehabilitation Project.

Thank you, Mr. Chairman, and the Committee.

I have to extend my thanks to the New Jersey state people, in general, and to the officially elected, who work very hard to make us feel that we are well-protected by good people around the world.

Recently, I came back from the refugees camp. And we monitored that the refugees camp in eastern Chad has been affected by the Sudanese intelligence group going inside the refugees camp to convince the refugees to turn back; and force, also, a Chadian government to also put some pressure on the refugees camp to go back to their lands, where there is no place to go in Sudan.

The killing in Sudan is continuing. The rape and burning of villages also is continuing. Sudan now has started a new campaign to have the same militias, that fought southern people for 30 years in Khartoum, now to have their role to intimidate the international community by going to Darfur and protect civilians. And this campaign is just 15 days ago. They distributed guns and tried to mobilize people in the name of Jihad and in the name of -- to protect Sudan from western invasions.

So the things in Darfur are worse, many times, than in 2003. So Sudanese government tried, also, to block the aid, which is going to the IDP camps by -- intimidate the international aid workers and the Darfurian activists who try to provide the international organizations with information about the genocide and the operation of the Jinjaweed. And many Darfurians are in detention, and some tribal leaders -- or some community leaders in Darfur are being killed. Two days ago, the community leaders of Darfur -- in the city Nyala, south of Darfur, had been assassinated at night, around 2:00 a.m. So the Sudanese government, now -- they have a more brutal role than ever before. And the peace talks in

Abuja doesn't make any progress because of the Sudanese government position. And they try to mobilize the Sudanese in the name of patriotism, and to step -- or to stand behind the government, and support the government. And the Arab League also try to have their agencies in Darfur to convince the Darfurians to stand behind their government, and support the government, and protect their land from new western invasion.

So that is the situation inside the IDP's camp, and inside the refugees camp also -- there is a new rebellion born. And that is a Chadian position against the current Chadian government, also. They are very supported by the Sudanese government. And they are operating on the west Sudan border, near the refugees camp in eastern Chad.

ASSEMBLYMAN PAYNE: Excuse me, clarify that for me. You say inside the refugee camps there are-- What's happening inside there now?

MR. OSMAN: Oh, inside the refugees camp there is Sudanese intelligence personnel who try to convince the refugees. And in doing that, the activists inside the refugees camp in Chad -- to encourage people to go back to Sudan.

ASSEMBLYMAN PAYNE: For what purpose?

MR. OSMAN: To convince the international community that things are going well, and there is a security, and there is a reconciliation. Because Sudanese government has a big campaign now, in Darfur, between the tribe -- tried to compromise -- between the Jinjaweed position and acceptance of the Jinjaweed living in the same land that the people are being forced to leave.

So people are in the refugees camp. They refuse to go back to Sudan until the security -- had been placed in the same villages that have been burned. So they don't want to go back. But the Sudanese government tried to convince them, by putting pressure on the Chadian government to force people to leave the camps and go back to Sudan.

ASSEMBLYMAN PAYNE: Is that what's happening now?

MR. OSMAN: That's what's happening now.

ASSEMBLYMAN PAYNE: The Chadian government is putting pressure on the refugees.

MR. OSMAN: On the refugees.

ASSEMBLYMAN PAYNE: And there's intelligence inside the camps, working to get them there.

MR. OSMAN: Yes.

ASSEMBLYMAN PAYNE: And then the purpose of -- to give the impression to the world that there's reconciliation there, going on now.

MR. OSMAN: There is reconciliation, yes, in Darfur.

ASSEMBLYMAN PAYNE: And what's happening to the refugees, when they do come back -- those who come back? Is the Jinjaweed still active there?

MR. OSMAN: The Jinjaweed is still putting them in the last point in western Sudan, just to receive them coming back. And killings will continue, and rape, and children abduction also. Because there is--

When I visited the refugees camp, over 8,000 urban children -- they live in such very tough conditions. And they don't know where -- apart from their families. So the same number of the children are now in the hands of the Jinjaweed militias-- And we don't know their future -- how

it looks like. And the Sudanese government is very reluctant to talk about those children who are in the hands of the Jinjaweed members now, in Darfur.

Thank you.

ASSEMBLYMAN PAYNE: Thank you very much.

Reverend, did you have--

ASSEMBLYMAN STEELE: No, no. It's just based on communication. There seems to be a setup for ambush -- to get them back, to give them the perception that reconciliation is taking place. But, yet ultimately, the mutilation continues, which is a very false hope for us. And it will continue to be a devastation for them.

ASSEMBLYMAN PAYNE: Thank you.

Ms. Blanche Foster.

B L A N C H E F O S T E R: Thank you.

I've come before you-- If you are interested in knowing some of the things that Darfur Rehabilitation Project has been doing -- that it might be working in concert with what you, yourself, are doing in order to keep the divestment in front of everyone's attention.

However, if you feel that this is a subject better suited for another time, then I don't need to testify at this moment. The choice is yours.

ASSEMBLYMAN PAYNE: We did have this hearing set up to hear more on the status of two things: one, the conditions in Darfur--

MS. FOSTER: Exactly.

ASSEMBLYMAN PAYNE: Whether they've changed, whether they've gotten better, worse, etc. And I think the previous person clarified some of that.

MS. FOSTER: That's good.

ASSEMBLYMAN PAYNE: If you have something that you would like to add, however, I don't want you to have come all the way down here-- If you feel there is something we should really keep in the forefront, please feel free to do so.

MS. FOSTER: Very shortly--

ASSEMBLYMAN PAYNE: Sure.

MS. FOSTER: I simply wanted you to be aware that the U.N., at this moment, is sending a peacekeeping troop over to Darfur and to several different areas in the Sudan. And the Darfur Rehabilitation Project has been interviewed by several of the people who are going there, who will be in different locations.

Also, we are meeting with the United States Institute of Peace, because -- although you know, the rest of your Committee may not know -- the Darfur Rehabilitation Project has a desire, above all, that any solution that happens is a peaceful solution that is brought about through reconciliation. So what we are doing is pulling together people of different groups throughout Sudan who will receive training, in a workshop, to learn how to best communicate the skills of peace and reconciliation. We are seeking funding. And these people will be sent back into the refugee camps in order to meet with the community leaders within the camps themselves.

Rehabilitation is a very important part of the name of our organization. It is our goal that when the people leave the refugee camps

and go back into Darfur, they will go back with some matrix, some means of communicating with each other, and being able to rebuild. And it is our hope that when these people who are trained, through USIP and our organization, will go back, meet with the leaders in the refugee camps, they will be better armed to rehabilitate in that area.

We continue to do things along those lines. I really won't take an awful lot of time at the moment, because I think-- I just wanted to give you a sense of what we, as an organization, are doing in this regard, to ameliorate the problems that are currently going on.

ASSEMBLYMAN PAYNE: Thank you.

Assemblyman Steele.

ASSEMBLYMAN STEELE: Thank you, Mr. Chairman.

What consists of the training and the skills for the whole reconciliation process that's being done?

MS. FOSTER: The United States Institute of Peace is very well experienced in helping countries get through conflict resolution. And what they will be doing is working with the different Darfurians who are in this country, so that they will be able to go back skilled in those tactics -- primarily conflict resolution, and bringing about peace through that means, rather than through military might.

If there are no other questions--

ASSEMBLYMAN STEELE: I hear exactly what you've said. I guess I commend you for being closer to the process now. But just from my information, I've seen the resistance and the hostility. I'm just trying to get my hand on, at what point is there any kind of beginning of agreement that

brings about a resolution to conflict, based on what I've seen in my involvement?

MS. FOSTER: At the moment, it's very dire.

ASSEMBLYMAN STEELE: Okay.

MS. FOSTER: There have been eight sessions at the peace talks in Abuja. They have not been effective. They primarily have not been effective, because the people who are there seem to be there for their own personal gain.

ASSEMBLYMAN STEELE: Right.

MS. FOSTER: Also, there have been attempts by representatives of the Sudanese government to influence people who are a part of those talks to change their way of thinking, once their hands are filled with some oil money from out of Sudan.

ASSEMBLYMAN STEELE: Okay.

MS. FOSTER: This is not hearsay. This is where people have actually commented to our Darfurian members of DRP -- that there have been attempts to influence them to not be part of the negotiations at Abuja.

ASSEMBLYMAN STEELE: Sure.

Thank you.

ASSEMBLYMAN PAYNE: Thank you, Assemblyman.

Wasn't a similar -- activity take place, of the peace and reconciliation, after South Africa -- in South Africa, with Bishop Tutu and the rest of them during that time? But that was after the fact, wasn't it? That was after the--

MS. FOSTER: After.

ASSEMBLYMAN PAYNE: --apartheid had been dismantled.

MS. FOSTER: Exactly.

ASSEMBLYMAN PAYNE: And this is what you're looking to have people trained -- so that when we finally can have some kind of reconciliation, these folks will be trained to be able to go in and try to--

MS. FOSTER: To do something that's effective.

What I'm really trying to point out -- and would like to do it with as few words as possible -- is that the device -- the divestment is crucially important.

ASSEMBLYMAN STEELE: Right. Okay.

MS. FOSTER: But there are other things that need to be kept in place while that is also occurring.

ASSEMBLYMAN STEELE: Sure.

ASSEMBLYMAN PAYNE: Absolutely. Sure.

MS. FOSTER: You're not working on your own, in the sense that-- I want to give you a hope factor--

ASSEMBLYMAN STEELE: Sure.

ASSEMBLYMAN PAYNE: Sure.

MS. FOSTER: --that we're very busily trying to work in concert with what you're doing.

ASSEMBLYMAN PAYNE: And you do say that this divestiture is crucial, is key.

MS. FOSTER: Oh, absolutely.

If you will-- I don't know if you have time, with your schedules-- But if you will look at the work of Eric Reeves, who is an expert in this area; if you will-- You have your own list that you've put together

that lists the different companies that are dealing there. I think, as has been pointed out, history has proven that divestment is a crucial tool.

ASSEMBLYMAN STEELE: Absolutely.

MS. FOSTER: And it is here in this case, as well.

ASSEMBLYMAN PAYNE: Thank you very much. I appreciate your coming down and continuing to fight. We have met, and we've worked on a number of related projects. Continue doing what you're doing. It may seem hopeless from time to time, but it has worked in the past, and it will work out here.

MS. FOSTER: I think so. We very much appreciate the support that we are receiving from this Committee.

If you think it is difficult for an immigrant to be in this country, imagine what it is like for an immigrant not to have the support of anyone in a country when you know, miles away, your people are being victims of genocide.

ASSEMBLYMAN STEELE: Sure.

MS. FOSTER: It just leaves them totally helpless.

So it's very valuable that you're sitting where you're sitting, and you're making the decisions that you're making.

Thank you.

ASSEMBLYMAN PAYNE: Thank you.

You -- Algira -- while you, the other -- Algira had the program--

MS. FOSTER: Yes.

ASSEMBLYMAN PAYNE: --the Darfurian.

MS. FOSTER: Do I get to put a plug in?

ASSEMBLYMAN PAYNE: Please, by all means.

MS. FOSTER: All right. I didn't know if you wanted it part of--

ASSEMBLYMAN PAYNE: Yes, sure.

MS. FOSTER: --part of the record.

Algira is an art studio that is in Newark, New Jersey -- 591 Broad Street. So it's easy for you to reach. There is an exhibit, at the moment, about Sudan. The photographs have been taken and supported by someone who used to be a diplomat working in Sudan. And beyond the beautiful photographs, that give Americans a chance to have empathy for Sudan, is yet another room where we have the artwork of Sudanese artists. And it will bring before you the plight of the people through art, in a way that I think you would not be able to leave the area without having some connection to these people.

In addition to which, it includes the artwork of Darfurian children. Jerry Ehrlich, who is of Doctors -- with Darfur -- Without Borders, was there. He passed out pieces of paper and crayons to the Darfurian children. And he slipped their artwork out of the country through the pages of the *New York Times*. So they didn't realize what he was doing. And he has given us, and anybody who can, the ability to just distribute his artwork -- the children's artwork wherever they can. And this artwork is filled with the helicopters that are going overhead that are used to bomb the houses. The artwork of children show the people with guns, they show people, children being -- just horrible things, which I won't take time to mention at the moment.

But through the eyes of children, you will be able to see what is actually happening there. And I absolutely encourage you to go there. If

you're not able to go, let us know. And I will see to it that I send you videos with their artwork, if not the artwork itself.

ASSEMBLYMAN PAYNE: Thank you.

MS. FOSTER: Thank you.

ASSEMBLYMAN PAYNE: I was there when they had the opening. A sad footnote to that, of course, is that the fellow that went to Brazil-- Was he the director of the (indiscernible)?

MS. FOSTER: Oh, yes. The sadness of that is that I was working with the curator, Ethan Hall -- a wonderful young fellow, 40 years old. He left our opening that night and went to Rio de Janeiro to celebrate Mardi Gras, and was killed in an auto accident. So it's particularly poignant, at this time, for all of us.

ASSEMBLYMAN PAYNE: Right.

Thank you very much.

MS. FOSTER: Thank you.

ASSEMBLYMAN PAYNE: Keep up the good work. And you can count on our support.

MS. FOSTER: I really do appreciate it.

ASSEMBLYMAN PAYNE: Now we'll have representatives from the New Jersey Treasury Department. I'm sure they've heard how important it is for the State to be involved in divestment.

Would you please come forward at this time?

Please give your name and identify yourself.

ASST. STATE TREASURER PATRICK O'CONNOR: Mr. Chairman, my name is Patrick O'Connor. I'm the Assistant State Treasurer.

J A M E S S O U D E R: My name is James Souder. I am Deputy Director of Legislative Affairs for the Treasurer.

ASSISTANT STATE TREASURER O'CONNOR: We're here today to give you a follow-up to the December report that was given to the Committee.

At this particular point in time, I just want to reemphasize the commitment to the divestiture by this Governor and this Treasurer, to accomplish what your objective is within the time frame in which the legislation calls for.

At this particular point, I'm told Treasury has identified about $1.4 billion in assets that need to be divested. We continue to work to see if there are additional investments that are in our portfolio to divest.

Presently, we have divested $300 million of that 1.4 approximate number. We have received verbal commitments to divest an additional $300 million-plus, and are in discussions to divest an additional $200 million. And we continue those discussions with companies to make sure that they comply.

And at this particular point in time, that's all I have to offer, officially.

At this point, I would like to respond to any questions you might have. I appreciate your patience today with us. I understand the importance of the issue.

Thank you.

ASSEMBLYMAN PAYNE: Thank you, Mr. O'Connor.

You've heard the testimony from the people who preceded you, ones who are directly involved in the situation. And I think that, from their

testimony, you can clearly understand the gravity of the situation that exists in the -- Darfur.

And as I said in the testimony earlier, on another topic -- that we have to put a face on what is going on in Darfur. We need to let people know and see the horrific things that are going on there, and to also understand that what we're talking about with that divestment does have an impact on the conditions there. It has an impact on the government there.

And New Jersey, we're proud to say, was the first state to pass the legislation to call -- about withdrawing of our investments, our pension moneys from companies that are doing business -- foreign companies doing business there. We're proud to say we're the first state. Illinois followed us. Illinois is moving along rather quickly. And it's my understanding that Illinois has divested some $8 billion so far. And I'm sure that we, here in New Jersey, will do everything we can to make sure that we do the very best that we can.

As a matter of fact, I think it's incumbent upon us to accelerate our efforts and intensify our efforts to do this. Because I think the more that we can show that we are in support of the people in the Darfur region, the ones that are being slaughtered, etc.-- It gives encouragement to them, and also gives encouragement to other entities around this country and the world.

As you may know, there are a number of universities and colleges that have moved forward and are divesting. And other states are attempting to do the same thing.

So I want New Jersey to be in the forefront of this. I really expect that we-- We have a Governor who has been to the region. And even though the previous Governor had not been, this Governor has been to the region. And I'm sure that this Governor would like to see us move in the forefront in this whole effort.

If you would, I would appreciate very much if you can convey to the Governor the testimony you heard today, through the people from the Treasury Department -- convey to the Governor how extremely important this is, and that we're looking for him and his administration to take the leadership in seeing to it that we can, in fact, stop this terrible, terrible condition that's going on there, the genocide there, and so on.

We appreciate your coming. And we would like to know-- For instance, you gave a figure of $1.4 billion.

ASSISTANT STATE TREASURER O'CONNOR: $1.4 billion is what I was told this morning.

ASSEMBLYMAN PAYNE: Please, if you will -- if you get to us-- Identify those companies from which that money was withdrawn. We would appreciate that as a follow-up.

ASSISTANT STATE TREASURER O'CONNOR: The $300 million, yes.

ASSEMBLYMAN PAYNE: Well, so far--

ASSISTANT STATE TREASURER O'CONNOR: The $1.4 billion is--

ASSEMBLYMAN PAYNE: --$1.4 billion--

ASSISTANT STATE TREASURER O'CONNOR: --what we were to divest.

ASSEMBLYMAN PAYNE: I'd like to know which companies they were withdrawn from.

ASSISTANT STATE TREASURER O'CONNOR: Sure.

ASSEMBLYMAN PAYNE: That would be very helpful to us.

We look forward to hearing-- There are quarterly reports that are to be given. And even though I think we have said that the legislation calls for a report over a period of time, if we can accelerate our efforts-- If we can see that what's happening in Darfur is getting even worse, we need to do everything we possibly can, here in New Jersey, to lead the way. I have confidence in Governor Corzine that he will, in fact, set the tone for us to move forward with this.

Thank you for coming.

I think Assemblyman Thompson has a question.

ASSEMBLYMAN THOMPSON: The numbers that you gave indicated that apparently, at this time, there are plans to divest $800 million of the $1.4 billion. There's (indiscernible).

ASSISTANT STATE TREASURER O'CONNOR: Right, right.

ASSEMBLYMAN THOMPSON: You also said that you're in ongoing discussions with companies to see that they divest. Do I interpret that to mean that in some of the cases, rather than actually divesting, you're speaking and negotiating with companies to have them, perhaps, pull out of Sudan?

ASSISTANT STATE TREASURER O'CONNOR: Yes.

MR. SOUDER: That's correct. The Treasury is pursuing this in a variety of ways, in terms of divesting in the Sudan. One of which is direct divestment, meaning pulling our money out of companies that are

doing business in Sudan. Other ways that we're doing that is putting pressure on companies, and discussing with companies, having them actually pull operations out of Sudan and not directly taking our money, then, out of those companies; which actually creates a larger effect, because it further effects the economy there.

One of the other ways that we're doing it--

ASSEMBLYMAN THOMPSON: I think that's fine. That's a very reasonable approach. And, certainly, if you can convince a company to pull out of Sudan, that would even have a greater impact than simply pulling our investment out of the company.

ASSEMBLYMAN PAYNE: Reverend?

ASSEMBLYMAN STEELE: No, Mr. Chairman. I just want to convey to the Governor, certainly, he has our support. We believe that this money is as critical as life. And procrastination is the thief of time. And if we don't be persistent and diligent in this effort, we're going to send a signal that they can use their money to undermine everything -- effort that we have done. And I believe that if we do this expeditiously, we will find out that eventually we will cripple that country. And they will fall to their knees, and reconciliation can take place. People can live at peace, and their lives can be made whole.

Thank you very much for being here today.

ASSISTANT STATE TREASURER O'CONNOR: Thank you.

ASSEMBLYMAN PAYNE: And rest assured that we are going to continue to monitor this, and hope that you will be able to come back to us.

Precedent has been set. I mean, this initiative was used to bring down apartheid in South Africa. If anyone questions whether this works, all they need to do is see where-- This State led the fight there, as well. And we want to be the ones that will be leading the fight. Okay?

ASSISTANT STATE TREASURER O'CONNOR: I remember 1984 -- Assemblyman Brown. I remember it well.

ASSEMBLYMAN PAYNE: Thank you very much.

ASSISTANT STATE TREASURER O'CONNOR: Thank you.

ASSEMBLYMAN PAYNE: This concludes this hearing.

Thank you.

(MEETING CONCLUDED)